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ABSTRACT

This study investigates the nature of therapist-client interactions within and across seven actual psychotherapy cases to investigate the assertion within interactional theories that positive therapeutic outcome is the result of a transition from relational incongruence to relational congruence. Counselor/client verbal utterances were coded using Stiles' verbal response taxonomy. A measure of counselor and client response redundancy (patterning) served as an index of relational congruence, with higher levels of redundancy reflecting greater congruence. Therapeutic outcome, operationalized in terms of symptom reduction, was assessed using the SCL-90-R psychological symptomology instrument. The Working Alliance Inventory was used as a construct validation measure for the index of relational congruence. A transition from incongruence to congruence was not evidenced in the cases, nor was a relation found between relational congruence and the Working Alliance Inventory. However, there was some support for the hypothesis that therapeutic change (symptom reduction) is related to relational congruence/incongruence. Further research to address the issues raised by this study is needed. (Contains 40 references.) (Author/KW)

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Relationship formation and change in psychotherapy: An analysis of cases

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Relationship formation and change in psychotherapy:

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Abstract

We investigated the nature of therapist-client interactions within and across seven actual psychotherapy cases to investigate the assertion within interactional theories that positive therapeutic outcome is the result of a transition from relational incongruence to relational congruence (Strong, 1982). Counselor/client verbal utterances were coded using Stiles' (1987) verbal response taxonomy. A measure of counselor and client response redundancy (patterning) served as an index of relational congruence, with higher levels of redundancy reflecting greater congruence. Therapeutic outcome, operationalized in terms of symptom reduction, was assessed using the SCL-90-R. The Working Alliance Inventory (WAI) was used as a construct validation measure for our index of relational congruence. A transition from incongruence to congruence was not evidenced in the cases, nor was a relation found between relational congruence and the WAI. However, there was some support limited for the hypothesis that therapeutic change (symptom reduction) related to relational congruence/incongruence.

Relationship formation and change in psychotherapy:
An analysis of cases

Introduction

Counseling psychologists commonly assume that therapeutic change occurs in counseling after a stable therapeutic relationship is established with a client. The interactional perspective orders these events in the reverse, proposing that therapeutic change is generated in the process of forming the relationship. This notion derives from an interactional analysis of the process of relationship formation (Claiborn & Lichtenberg, 1989). When a therapist and client meet, they begin their encounter with individual notions of what their relationship should be like, based on their definitions of the desired relationship. As they interact with one another, each attempts to influence the other to respond in a manner consistent with his or her definition of the relationship. When both interpret each other's behavior as congruent with their desired definitions, the relationship is congruent; and the ongoing interaction will tend to maintain the structure and definition of the relationship. If either or both parties find the interaction to be discrepant with their desired relationship definition, the relationship is said to be incongruent. Further interactions then will be an attempt to bring the relationship into congruence with one's desired definition by influencing the other to respond in the desired fashion. The outcome of the struggle to achieve congruence in the therapeutic interaction can be (a) change which results in the attainment of each party's desired relationship, (b) changes in one or both parties' definition of the desired relationship, (c) termination of the relationship, or (d) persistent efforts to bring the other's behavior into line with one's definition of the desired relationship--a stable yet incongruent relationship characterized by conflict and tenacious continuance (Strong, 1982).

Stability in a relationship refers to its continuance; congruence refers to the mutuality of the definitions of what the relationship should be. These concepts combine to form a four-fold classification of relationships: (a) *stable congruent* relationships--characterized by mutually

agreeable interactions without interruptions of discrepancy, change or discontinuance, (b) *unstable congruent* relationships--characterized by mutuality but interruptions or discontinuance, (c) *stable incongruent* relationships--characterized by constant efforts toward change, yet a tacit acceptance of repeating patterns of disagreement, and (d) *unstable incongruent* relationships--characterized by efforts toward change and the threat of termination.

Strong (1982) proposes that in order to generate therapeutic client change, psychotherapy must be an unstable incongruent relationship, characterized by efforts by the therapist and the client to induced change in their relationship; it is "therapeutic" when the outcome of the relationship is the therapeutic change of the client. Successful psychotherapy, then, evolves from an unstable incongruent relationship into an unstable congruent relationship. (NOTE: Although some psychotherapy may continue for several years, the therapeutic relationship is [by definition] a time-limited and thus unstable, relationship.) To have a therapeutic outcome, Strong (1982) proposes that the key dynamics of therapy are that therapist must (a) prevent the relationship from being terminated before therapeutic change is achieved, (b) prevent the unstable incongruent relationship from degenerating into a stable incongruent relationship that goes on indefinitely without achieving therapeutic change, and (c) determine who changes and how they change.

To date, research on the therapeutic relationship from this perspective has focused largely on the issue of "relational control" in therapy; i.e., on who determines the relational changes within and across therapy (e.g., Beck & Strong, 1982; Claiborn & Lichtenberg, 1989; Kiesler & Goldston, 1988; Lichtenberg & Barké, 1981; Lichtenberg & Heck, 1986; Strong et al., 1988; Tracey, 1985; Tracey, 1987; Tracey, Heck & Lichtenberg, 1981; Tracey & Ray, 1984). The nature of the relationship (congruent/incongruent) and its change (if unstable) across the therapy process have not been studied--although both notions are central to the interactional theory of therapeutic change.

It was the purpose of this study to investigate the nature of therapist-client interactions within and across actual psychotherapy cases--in order to investigate the assertion within interactional theories that positive therapeutic outcome is the result of a transition from relational incongruence to relational congruence. Specifically this study investigated (a) whether the therapy

relationship progresses from relative incongruence to congruence across sessions of a case and (b) whether transition from relational incongruence to congruence correlates with reductions in psychological symptoms. In light of the above mentioned tenets of interactional theory, it was hypothesized that relational congruence would increase across therapy sessions within therapy cases, and that such increases in congruence would correlate with a reduction in psychological symptoms. Finally, the relation between relational congruence and the therapeutic alliance was examined. It was believed that both constructs are theoretically similar and ought to be statistically related, and therefore it was hypothesized that measures of the working alliance would correlate positively with our measures of relational congruence. The relationship between these two constructs was examined as a means of testing the validity of the our operationalization of the construct of relational congruence.

Method

Data

Interview transcriptions and therapy process and outcome ratings of seven actual full-length psychotherapy cases served as the basis for the study. Cases ranged in length from 12 to 20 sessions (M = 16.42, SD = 3.31, Mdn and Mode = 17). Transcriptions of the cases were prepared as part of a NIMH-funded study of therapist techniques and client outcomes (Hill, 1989). Process measures of relationship quality were collected by Hill during this same study, as were client outcome measures of symptom occurrence (see below). The interview transcriptions and the process and outcome measure ratings were made available to these researchers for additional study. The written transcriptions comprised a total of 115 interviews.

Hill (1989) describes the therapists as "master psychotherapists who believed in and were competent in time-limited therapy" (p. 24). The seven therapists (4 male, 3 female) were all Ph.D. psychologists who ranged in age from 34 to 78 (M = 47.14, SD = 14.46) and averaged 18.5 years of postdoctoral experience. Six of the therapists were White; one was Black.

Clients all were women; they ranged in age from 32 to 60 (M = 43.28, SD = 9.62). Five of the clients were White; one was Asian; and one was Arabic. The clients had been recruited through newspaper announcements that offered free individual therapy for women over 25 who

had self-esteem and relationship problems. Additionally, to qualify for the study, participants must have had no previous psychotherapy experience and no history of alcohol or drug abuse. Hill (1989) reports receiving 94 appropriate phone inquiries about the study. Of these, 53 completed a battery of psychological screening instruments. Persons selected for inclusion in the study from this pool were identified by Hill as anxious and depressed, based in part on their elevated scores on the MMPI scales 2 (depression) and 7 (psychasthenia). Clients who were not selected for participation in the study were given referrals.

Table 1 summarizes the therapist and client demographic information for each of the seven cases.

Insert Table 1 about here

Coding. The transcribed verbal responses of the therapists and clients were coded using Stiles' (1987) taxonomy of verbal response modes (VRM) for coding interpersonal communication. The taxonomy classifies verbal responses into eight response modes (Disclosure, Advisement, Edification, Confirmation, Question, Interpretation, Acknowledgment, Reflection) based on a well-articulated conceptual system of classification principles (see Stiles, 1986) which consider (a) the source of the experience being reported in the utterance, (b) the frame of reference or viewpoint using in making the utterance, and (c) the focus of the utterance or whether the speaker, in making the utterance implicitly presumes to know the other's experience or frame of reference. Each of these three classification principles can have a value of "speaker" or "other" -- thereby yielding a 2x2x2 classification scheme (see Table 2). Coding is done for both the form and the intent of the communication. Previous research (see Stiles, 1987) supports that coding using the VRM can be done reliably (k=.56-96 for form; k=.36-89 for intent). For purposes of this study, only ratings of communication intent were considered. Rater reliability for the study was good (all kappa's >.70). Stiles' VRM system has been used extensively and productively in numerous research studies of therapist/client verbal interaction (e.g., Stiles, 1987; Stiles & Sultan, 1979).

Insert Table 2 about here

Following Stiles' recommendation (Stiles, 1986, 1987), response codes were collapsed across "role dimensions" in order to reduce the number of response utterances needed to achieve stable response transition probabilities and to facilitate data analysis. Collapsing the eight response modes yielded three distinctive role dimension response categories: (a) utterances concerning the other's experience--attentiveness (Question, Interpretation, Acknowledgment, Reflection) vs. informativeness (Disclosure, Edification, Advisement, Confirmation), (b) utterances using the other's frame of reference--acquiescence (Edification, Confirmation, Acknowledgment, Reflection) vs. directiveness (Disclosure, Advisement, Question, Interpretation), and (c) utterances focused on the other--presumptuousness (Advisement, Confirmation, Interpretation, Reflection) vs. unassumingness (Disclosure, Edification, Question, Acknowledgment) (Stiles, 1986, p. 178). Previous research on these derived role dimension response categories has supported their construct validity (e.g., Cansler & Stiles, 1981; Stiles, 1979; Stiles, Waszak & Barton, 1979).

Insert Table 3 about here

Instruments

One process and one outcome measure were used. Data on both measures were collected as part of an earlier research study (Hill, 1989).

Working Alliance Inventory (WAI; Horvath & Greenberg, 1986). The WAI was developed by Horvath and Greenberg (1986) as a measure of three specific process variables that Bordin (1979) proposed as central to an effective working relationship between a therapist and a client: (a) agreement and mutual valuing of the aims and purpose of the therapeutic intervention (goals), (b) agreement and mutual acceptance of the relevant tasks to be carried out during therapy (tasks), and (c) a positive personal attachment between the therapist and client--one based on mutual acceptance, trust and confidence (bonds). Various studies have suggested the working alliance (as measured by the WAI) to be predictive of therapy outcome (e.g., Horvath &

Greenberg, 1989; Tichenor & Hill, 1989), although Kokotovick and Tracey (1990) did not find the WAI to be predictive of premature termination from counseling.

The WAI consists of three subscales (bond, task, goal), each with 12 items rated on a 7-point Likert scale, and each measuring one of Bordin's (1979) three theoretically important aspects of the therapeutic relationship. Horvath and Greenberg (1986) report overall internal consistency coefficients (Cronbach's alpha) of .93 and .87 respectively for the client and therapist versions of the instrument. Hoyt internal consistency estimates for the individual subscales of the client version of the WAI are .88 (goal), .88 (task) and .85 (bond). For the therapist version of the instrument, these estimates are .87 (goal), .82 (task) and .68 (bond). With the exception of the therapist WAI-bond subscale (which may be influenced by a possible "ceiling effect" resulting from therapists being asked to rate themselves; Horvath & Greenberg, 1986), these reliability coefficients are quite acceptable for a self-report instrument. Horvath and Greenberg (1986) report correlations between client WAI ratings and PTQ (Client Posttherapy Questionnaire; Strupp, Wallach & Wogan, 1964) ratings of satisfaction and change as: task/satisfaction = .65, bond/satisfaction = .32, goal/satisfaction = .40, overall/satisfaction = .50, task/change = .45, bond/change = .23, goal/change = .24, overall/change = .33. Similar correlations for therapist ratings are reported as: task/satisfaction = .68, bond/satisfaction = .48, goal/satisfaction = .60, overall/satisfaction = .66, task/change = .37, bond/change = .47, goal/change = .22, overall/change = .38. The results of these correlations suggest that the client task ratings are the most effective in predicting client-reported satisfaction and change. They also suggest that while therapist task ratings are most effective in predicting therapist-reported client satisfaction, therapist bond ratings are more effective in predicting their report of client change.

Symptom Checklist-90-Revised (SCL-90-R; Derogatis, Rickels & Rock, 1976). The SCL-90-R is a 90 item self-report measure of psychological symptomology. The instrument assesses symptoms along nine primary symptom dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism), and includes three global indices of distress: Global Severity Index (GSI), Positive Symptom Total, and Positive Symptom Distress. Derogatis, Rickels and Rock (1976)

report indices of internal consistency (alphas) for the nine symptom dimensions to range from .77 (psychoticism) to .90 (depression). Test-retest reliability coefficients computed on a sample of 94 outpatients who completed the SCL-90-R during an initial evaluation and again before their first therapy hour are reported to range from .78 (hostility) to .90 (phobic anxiety) (Derogatis, 1977). This and other studies (e.g., Rhoads, 1983; Speer & Swindle, 1982) suggest scores on the SCL-90-R to be fairly stable over time, yet sensitive to treatment effects and suitable as a criterion measure in evaluating psychotherapy outcome (Tennen, Affleck, & Herzberger, 1985).

For purposes of this study, the Global Severity Index (GSI), which is a function of the number of reported symptoms and intensity of distress, was used as an index of therapeutic outcome for each of the seven cases. Derogatis (1977) reports a two-week test-retest reliability coefficient of .90 for a sample of 60 nonpatients. Therapeutic improvement was indicated by a reduction in GSI scores.

Relational Congruence

Consistent with suggestions in previous writings (e.g., Claiborn & Lichtenberg, 1989; Lichtenberg & Knox, 1991), and drawing upon Shannon and Weaver's (1949) mathematical theory of communication (also see Attneave, 1959; Penman, 1980), relational incongruence was operationalized as the degree of randomness (uncertainty) or absence of patterning in the verbal interactions (conditional responding) of therapists and clients. Conversely, relational congruence was operationalized as the degree of patterning in the verbal interactions of therapist and client. Specifically, the more incongruent the relationship, the more random or uncertain and the less patterned the verbal exchanges of the therapist and client. Our reasoning was that as relationships achieve congruence, they also become better defined (Haley, 1963); and as they become better defined, they become more patterned or structured (i.e., the responses of the interactants become more predictable and their occurrence less uncertain).

In order to assess relational congruence, the following indices of structure were computed (see Attneave, 1959, for computational formulae): (a) Entropy (**H**)--a measure of the degree of randomness or disorganization of the various joint occurrences (or pairs) of therapist/client interactive responses, (b) Maximum entropy ($\mathbf{H}_{max}$)--the entropy value for a set of *m* events

(therapist-client response pairs) in which the various therapist and client interactive responses are all equally likely (i.e., in which randomness and disorganization [lack of patterning] among responses would be at a maximum), (c) Relative entropy (**RE**)--the ratio of the actual entropy (disorganization) in the various joint occurrences of therapist/client responses to the maximum possible degree of disorganization among those responses ($\mathbf{RE=H/H_{max}}$), (d) Redundancy (**R**)--an index of response patterning, computed as the proportional complement of relative entropy (**R=1-RE**). Although the above indices are obviously related to one another, for the present study, the last index of response redundancy served as the primary index response patterning/structure and so of relational congruence/incongruence. The other indices were computed as necessary for the determination of response redundancy.

Analyses

Each psychotherapy case was analyzed individually. For each case, indices of redundancy (relational congruence) were calculated for each of the three VRM role dimensions (attentiveness vs. informativeness, directiveness vs. acquiescence, and presumptuousness vs. unassumingness) for each session and correlated with session number. A positive correlation between session number and the index of redundancy for each of the role dimensions was expected; that is, it was expected that as session number (within a case) increased, redundancy (the response patterning of the therapist-client interaction along each role dimension) also would increase. This was thought to reflect an increase in relational definition and congruence as the case progressed across sessions. Additionally, the indices of response redundancy were correlated with therapist and client ratings of the working alliance (WAI) for each session, with positive correlations expected; that is, greater relational congruence would be related to a stronger working alliance. Finally, the cases were combined to assess the relation between the change in congruence and the change in psychological symptoms. It was expected that greater across-session increases in relational congruence would be associated with greater reductions in psychological symptoms (as measured by the SCL-90-R).

Assessing the relationship between changes in congruence and changes in psychological symptoms involved a series steps. First, each counseling case was divided into quarters by sessions. The means of the indices of redundancy for each session within the first quarter of each

case and within the last quarter of each case then were computed for each of the VRM role dimensions. Indices computed for case quarters were used instead of the indices for individual sessions because quarters were believed to provide more stable and reliable measures of relationship congruence/incongruence at the beginning and end of each case. In this regard, previous research (e.g., Lichtenberg & Heck, 1979; Tracey & Ray, 1984) has revealed an initial relational congruence between client and therapist during the first session followed by a marked decrease in congruence in subsequent sessions. By analyzing quarters, this initial congruence which may not accurately present the character of the therapy relationship, can be accounted for.

Next, the difference between last quarter and first quarter redundancy indices was computed for each case and rank ordered--the higher the positive difference the greater the change in redundancy (i.e., the greater the change toward congruence from the beginning to the end of therapy), the higher the rank for that case.

Changes in SCL-90-R scores were computed for each case. Changes were computed between a pre-treatment assessment and two separate post-treatment assessments: (a) a post-treatment assessment made immediately following treatment, and (b) a 6-month post-treatment follow-up assessment. Each of these change scores was rank ordered, with the highest amount of change being assigned the highest rank.

Finally, Spearman rank-order correlations (ρ) were computed to determine the relation between the SCL-90-R rank ordered change scores (pre-treatment to post-treatment, pre-treatment to 6-month post-treatment follow-up) and the rank ordered redundancy change scores for each of the VRM role dimensions. The Spearman rank correlations were used instead of the Pearson product-moment correlations because they allowed for a more sensitive test of the relationships between changes in redundancy and symptomology given our small number of cases (n=7).

Results

In general (i.e., across the seven therapy cases), the results failed to support the notion of a transition from incongruence to congruence across sessions within individual cases. With the exceptions of the correlations between session number and the response patterning along the directiveness/acquiescence role dimension for cases 2 ($r = .744$, $p<.01$) and 5 ($r = .491$, $p<.05$),

the correlations between session number and the redundancy (relationship congruence) indices for each of the three VRM role dimensions (our measure of relationship congruence/incongruence) generally were either non-significant or in the wrong direction (see Table 4).

Insert Table 4 about here

Nor was relationship development (indexed in terms of response redundancy for the various role dimensions) related to the development of the working alliance (see Table 5). In this instance, the correlations between redundancy and WAI subscales were also generally non-significant, or significant in the wrong direction.

Insert Table 5 about here

A significant relationship between the ranked changes in relationship congruence and psychological symptom reduction was found on the role dimensions of attentiveness/informativeness ($\rho = .822$, $p<.01$) and presumptuousness/unassumingness ($\rho = .779$, $p<.05$) when symptom change was measured immediately following treatment. This relationship was not found for the directiveness/acquiescence role dimension. Nor was any relationship found between change in relationship congruence and symptom reduction at 6 months following treatment (see Table 6).

Insert Table 6 about here

Discussion

On the whole, the results of this study do not appear supportive of the interactional psychotherapy's position that a positive therapeutic outcome is the result of a transition from relational incongruence to relational congruence (Strong, 1982). The lack of development of congruence across sessions raises question as to the validity of the interactional perspective's assumption that relationship development within therapy is the vehicle by which therapeutic change is brought about. In each of the seven cases analyzed, no consistent progression toward a more

congruent relationship was noted--at least as defined by our measure of relational congruence (redundancy) and as assessed the role dimensions of attentiveness/informativeness, acquiescence/directiveness, and presumptuousness/unassumingness. While it might be argued that a transition from incongruence to congruence across sessions reasonably should be expected only for successful cases (since such change is believed to be the mechanism of change), other analyses in this study (specifically, those of the relation between change in congruence and change in symptoms) would not support this argument. Further, in considering the apparent lack of transition toward congruence across case sessions, we must acknowledge that it is unknown how much of a change toward greater redundancy is to be expected or is needed (theoretically) to promote therapeutic change.

In considering this finding, it is also important to keep in mind that the measure of congruence/redundancy is inherently a function of the response categories studied--in this case, the VRM role dimensions of attentiveness/informativeness, directiveness/acquiescence, and presumptuousness/unassumingness. Thus, even though there may have been limited movement toward congruence on the VRM measures, coding the responses using some other system may have revealed the expected transition to relational congruence. Although the VRM dimensions used in the present study continue to seem relevant to these researchers, it is possible that some other response/behavioral dimensions of therapist-client interaction may be more useful in measuring relational congruence and relational change (e.g., Hill, 1986; Strong & Hills, 1986).

The lack of relation between the WAI and response patterning suggests that the concept of redundancy may be a poor measure of relationship congruence. The WAI, which has an impressive history of studies regarding relationship formation and the relation between the therapeutic working alliance and therapeutic outcome, was expected to correlate positively with our measure of relational congruence; that is, the working alliance was expected to increase (become more positive) as relational congruence increased. We are unable to offer a theoretical explanation for the lack of relation between the congruence and working alliance constructs, but would suggest that (as already noted) coding the verbal responses of clients and therapists using another system may have revealed the expected correlation between these two constructs. That is, the role

dimensions measured by the VRM may have failed to tap meaningful relational dimensions in the therapist-client relationship.

The finding of the relation between change toward relational congruence (redundancy) and change in psychological symptomology provides some limited support for the hypothesis within interactional theory that positive therapeutic outcome is the result of a transition from relational incongruence to relational congruence. It is important to note, however, that this relationship was apparent only with regard to change in symptoms immediately following treatment. At six months following treatment assessment, this relationship between relational congruence and symptom reduction was no longer significant--a result of an increase in symptomology for three of the cases over the six months following treatment (although for three of the other four cases, further symptom reduction at six months was apparent). What is not clear from our study, however, is whether the change in symptoms at six months for the three cases in which symptomology increased (as measured by SCL-90-R) reflects a <u>return</u> of earlier symptoms (specifically the ones for which the clients sought treatment) or whether it reflects the development of <u>new</u> symptoms.

On a related matter, although the SCL-90-R provides an reasonable assessment of the change in psychological symptoms (Tennen et al., 1985), the relation between <u>specific</u> problems and symptom reduction is not accounted for in the present study. That is, if the client had a single presenting problem to be addressed in therapy and this problem were successfully addressed in therapy, the SCL-90-R may reflect only a small change in the total number of symptoms reported. This small change may not be indicative of the actual benefits (or "success") of therapy as experienced by the client.

Also, with regard to the relation between change toward relational congruence and symptom reduction, we must again note that it is unknown how much of a change toward greater redundancy is to be expected or is needed (theoretically) to promote therapeutic change (i.e., symptom reduction). If only a small change in response patterning (congruence) is diagnostic, the relation between congruence and therapeutic change may go undetected. This may have been the case in the present study.

Finally, the present study does not account for an important component of interactional theory--who controls the definition of the therapeutic relationship. Haley (1963) and others (Cashdan, 1973; Strong & Claiborn, 1982; Tracey, 1985) maintain that the therapist must be in control in order to "pull" the client into a more appropriate way of behaving. If the client controls the definition of the relationship, then therapy is hypothesized to be relatively unsuccessful, even if (a) there is an increase in relational congruence (redundancy), (b) there is a belief by the client (and/or therapist) that the sessions are beneficial, and (c) there is an agreement on goals, tasks, and bond of therapy. It is presumed that because the client controls the relationship definition, the client will still be behaving in the same inappropriate (symptomatic) ways that are the source of the client's difficulties and that therapeutic change, therefore, has not been brought about. In this regard, Strong (1982) comments that, "A major tenet of interpersonal psychotherapy is that clients attempt to control therapists with symptomatic behavior and, if they succeed, relationships with therapists will maintain rather than disrupt client symptoms " (p. 199). Although a central tenet of interactional theory, the present study made no assessment of who controlled the definition of the relationship (however, see Lichtenberg, et al., 1995).

Further research to address the issues raised above is needed. Specifically, a replication of this study using a larger number of subjects is warranted in order to increase the sensitivity of the statistical measures. Additionally, further examination of the convergent validity of redundancy (or response patterning) is necessary, particularly in regard to the theoretical similarity between relational congruence and working alliance. The present study provided little statistical support for this theoretical similarity. And finally, replication of this study using other coding methods (e.g., Hill, 1986; Strong & Hills, 1986; Tracey, 1987) will provide further information regarding the development of the therapeutic relationship and therapeutic change.

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Table 1

Summary of Therapist and Client Demographic and Case Information[1]

Case #	Sex	Age	#Sessions in case	Race/ ethnicity
Case 1				
Therapist	M	47	20	White
Client	F	35		Arabic
Case 2				
Therapist	F	47	17	White
Client	F	51		White
Case 3				
Therapist	M	43	17	White
Client	F	60		White
Case 4				
Therapist	F	37	12	Black
Client	F	44		Asian
Case 5				
Therapist	M	34	17	White
Client	F	42		White
Case 6				
Therapist	M	44	20	White
Client	F	32		White
Case 7				
Therapist	F	78	12	White
Client	F	39		White

[1] See Hill (1989) for complete case information

Table 2

Taxonomy of Verbal Response Modes (Stiles, 1987)

Source of Experience	Frame of Reference	Focus	
		Speaker	Other
Speaker	Speaker	Disclosure	Advisement
Speaker	Other	Edification	Confirmation
Other	Speaker	Question	Interpretation
Other	Other	Acknowledgment	Reflection

Table 3

Role Dimension Response Categories (from Stiles, 1986, p. 178)

(a) Utterances concerning the other's experience:

Attentiveness (Question, Interpretation, Acknowledgment, Reflection) vs.

Informativeness (Disclosure, Edification, Advisement, Confirmation)

(b) Utterances using the other's frame of reference

Acquiescence (Edification, Confirmation, Acknowledgment, Reflection) vs.

Directiveness (Disclosure, Advisement, Question, Interpretation)

(c) Utterances focused on the other

Presumptuousness (Advisement, Confirmation, Interpretation, Reflection) vs.

Unassumingness (Disclosure, Edification, Question, Acknowledgment)

Table 4

Correlations Between Session Number and Relational Congruence (Session Redundancy) with Regard to VRM Role Dimensions (Verbal Attentiveness, Directiveness and Presumptuousness)

	VRM Role Dimensions		
Case #	Attentiveness[1] w/Session	Directiveness[3] w/Session	Presumptuousness[3] w/Session
1	.113	-.219	.518 *
2	.121	.744 **	-.049
3	.059	-.151	-.158
4	-.772 **	-.069	-.870 **
5	.092	.491 *	.224
6	-.745 **	.082	-.504 *
7	-.471	.116	-.237

* p <.05 ** p<.01

[1] Attentiveness/Informativeness role dimension

[2] Directiveness/Acquiescence role dimension

[3] Presumptuousness/Unassumingness role dimension

Table 5

Correlations Between the Working Alliance (WAI; as Rated by the Client and Therapist) and Redundancy with Regard to Verbal Attentiveness, Directiveness and Presumptuousness.

Case #	**Client** WAI w/Attentiveness Redundancy	**Client** WAI w/Directiveness Redundancy	**Client** WAI w/Presumptuousness Redundancy
1	.144	-.356	.318
2	.068	.677**	.006
3	.425	-.257	.022
4	-.180	-.182	.098
5	.311	-.145	.063
6	.309	.485**	.177
7	.342	-.158	-.134

Case #	**Therapist** WAI w/Attentiveness Redundancy	**Therapist** WAI w/Directiveness Redundancy	**Therapist** WAI w/Presumptuousness Redundancy
1	.104	-.034	.162
2	-.106	.367	-.136
3	.393	-.338	-.016
4	-.679*	-.009	-.544
5	.446	.469	.311
6	-.596**	.193	-.487*
7	-.058	-.025	-.228

Note. WAI = Working Alliance Inventory

* p <.05 ** p<.01

Table 6

Spearman Rank Correlations Between Pre-Post Changes in Relationship Congruence (Response Redundancy) and Changes in Psychological Symptoms (SCL-90-R) Immediately Following and 6 Months Following Treatment

Relationship Congruence Role Dimension	Pretest - Posttest	Pretest - 6 Month Follow-up
Attentiveness/ Informativeness	.822**	.253
Directiveness/ Acquiescence	-.076	.186
Presumptuousness/ Unassumingness	.786*	.550

* p <.05 ** p <.0